

(PLEASE PRINT OR TYPE) #0508 HIPS

Your Last Name Menna First Name Leonard Middle Name J Sex ☒ M ☐ F Date of Birth Mo. Day Year

Address [REDACTED] Zip Code 11414

Social Security # [REDACTED] Home Telephone [REDACTED]

Name of Employer Liberty Ashes Date Employed 11/8/07

Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe) Carol Menna Relationship Mother

Are you covered by any other Health Insurance? ☐ Yes ☒ No ☐ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☒

List Below all family members to be covered

Name	Birth Date	Relationship
Indicate different last name if applicable	MO DAY YR	
SPOUSE'S NAME LAST (If Different) FIRST SS#	/ /	<input type="checkbox"/> Husband <input type="checkbox"/> Wife
DEPENDENT LAST (If Different) FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT LAST (If Different) FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT LAST (If Different) FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT LAST (If Different) FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter

I hereby apply for that coverage for which I am or may become eligible under the group policy or policies issued by L.I.F.E. (Benefit Plan). I authorize such deductions, if any, from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under any life insurance issued and certify that the above is my correct date of birth. I have read this and it has been explained to me and I am signing on the reverse side.

HIP

S- 01/08 **LIFE**
League of International Federated Employees
325-73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages initiation fees and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

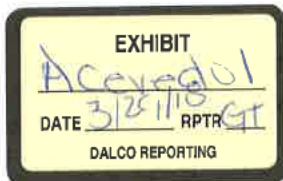
"Contributions of gifts to L.I.F.E. are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature [Signature] Date 12/21/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL

(OVER)



(PLEASE PRINT OR TYPE) #0509 HIP

Your Last Name MENNA First Name Leonard Middle Name J Sex ☒ M ☐ F Date of Birth Mo. Day Year 11/4/14

Address [REDACTED] Zip Code 11414

Home Telephone [REDACTED]

Name of Employer Leisure Ashes Date Employed 11/8/07

Full Name of Beneficiary (Example: Mary Doe Mr. and Mrs. John Doe) Carol Menna Relationship Mother

Are you covered by any other Health Insurance? ☐ Yes ☒ No ☐ Carrier

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☒

List below all family members to be covered			Birth Date	Relationship
Name <small>Indicate different last name if applicable</small>			MO DAY YR	
SPOUSE'S NAME	LAST (If Different)	FIRST	/ /	<input type="checkbox"/> Husband <input type="checkbox"/> Wife
DEPENDENT	LAST (If Different)	FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (If Different)	FIRST	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter

I hereby apply for that coverage for which I am or may become eligible under the group policy or policies issued by LIFE Benefit Plan. I authorize such deductions, if any, from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under any life insurance issued, and certify that the above is my correct date of birth. I have read this or it has been explained to me and I am signing on the reverse side.

HIP

S- 01/08

LIFE

League of International Federated Employees
325-73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages initiation fees and dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

"Contributions of gifts to LIFE are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature [Signature]Date 12/21/07

(Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL

(OVER)

(PLEASE PRINT OR TYPE)

Your Last Name Alcavallo First Name Louis Middle Name _____ Sex ☒ M ☐ F Date of Birth Mo. Day Year 11/17/41

Address _____ City _____ State NY Zip Code 11417

Social Security Number _____ Home Telephone # _____

Name of Employer Liberty Ashes Inc. Date Employed 3/17/10

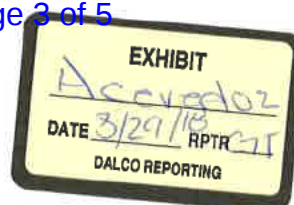
Full Name of Beneficiary (Example: Mary Doe Mr. and Mrs. John Doe) _____ Relationship Wife

Are you covered by any other Health Insurance? ☐ Yes ☒ No Carrier _____

If dependent coverage is provided, do you have eligible dependents? ☐ Yes ☒ No

List below all family members to be covered			Birth Date	Relationship
Name	MO	DAY	YR	
Indicate different last name if applicable				
SPouses Name	LAST (if Different)	FIRST		<input type="checkbox"/> Husband <input type="checkbox"/> Wife
DEPENDENT	LAST (if Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (if Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (if Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (if Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (if Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter

I hereby apply for the coverage for which I am or may become eligible under the Group Policy or Policies issued by L.I.F.E. Benefit Plan. I authorize such deduction from my earnings as may be required as my contribution to the cost of such coverage. I recognize the above as my beneficiary under this insurance coverage and certify that the above is my true and correct name. I have read this plan and have explained to myself and I am signed on the reverse side.



LIFE

League of International Federated Employees
325 THIRD STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize and irrevocably direct my Employer to deduct from my wages a portion of the dues uniformly required by said Union as a condition of acquiring membership therein, and in compliance with the National Labor Relations Act of 1974.

The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me at any anniversary date hereof, by written notice of such revocation sent to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by first notice prior to such termination date, whichever is earlier.

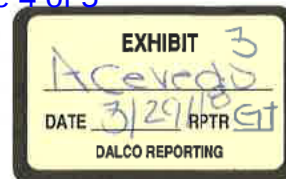
Contributions of gifts to L.I.F.E. are not tax deductible or charitable contributions. However, they may be deducted as ordinary and necessary business expenses.

Signature _____

(Please Answer All Questions on the Reverse Side)

ALL REPLY'S WILL BE KEPT STRICTLY CONFIDENTIAL

(OVER)



(PLEASE PRINT OR TYPE)

Your Last Name: Acervolo First Name: Louis Middle Name: _____ Sex: ☒ M ☐ F Date of Birth: 3/29/10

Address: _____ City: _____ State: NY Zip Code: 11417

Home Telephone #: (347) 405-4012

Name of Employer: Liberty ASACs Inc. Date Employed: 3/17/10

Full Name of Beneficiary (Example: Mary Doe Mr. and Mrs. John Doe): Acervolo, Louis Relationship: Wife

Are you covered by any other Health Insurance? ☐ Yes ☒ No ☐ Carrier: _____

If dependent coverage is provided, do you have eligible dependents? Yes ☐ No ☒

List below all family members to be covered			Birth Date	Relationship
Name	MO	DAY	YR	
Indicate different last name if applicable				
SPOUSE'S NAME	LAST (If Different)	FIRST		<input type="checkbox"/> Husband <input type="checkbox"/> Wife
DEPENDENT	LAST (If Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (If Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (If Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
DEPENDENT	LAST (If Different)	FIRST		<input type="checkbox"/> Son <input type="checkbox"/> Daughter

I hereby apply for Health Insurance for myself and/or my dependent(s) under the group policy or policies issued by L.I.F.E. Benefit Plan. I authorize such deduction(s) from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under this Health Insurance policy, and certify that the above is my correct name of birth. I have read this and have explained to myself and I am signing this coverage form.

LIFE

League of International Federated Employees

325 73rd STREET • BROOKLYN, N.Y. 11209 • (718) 238-2399

APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

The undersigned, hereby apply for membership in the above Union and I authorize it to represent me for the purpose of collective bargaining, and I authorize said irrevocably direct my Employer to deduct from my wages the amount of dues uniformly required by said Union as a condition of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974.

The amount deducted each month shall be forwarded to the Secretary/Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation given by me and given to my Employer and the Union by certified mail, not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

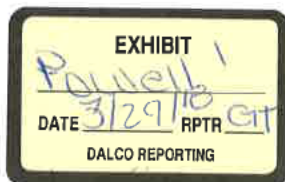
Contributions of gifts to L.I.F.E. are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses.

Signature: [Signature] Date: 6/17/10

(Please Answer All Questions in Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL

(OVER)



LBP → *6/15* **LIFE** JUN 19 2015
 League of International Federated Employees
 325 7th STREET • BROOKLYN, N.Y. 11203 • (718) 238-2399
single *as per Francisco*
 APPLICATION AND CHECK-OFF AUTHORIZATION BLANK

I, the undersigned, hereby apply for membership in the Above Union and authorize it to represent me for the purpose of collective bargaining, and I authorize and agree to have my Employer to deduct from my wages the dues, fees and dues uniformly required by said Union and the cost of acquiring or maintaining membership, and in compliance with the National Labor Relations Act of 1974. The amount deducted each month shall be forwarded to the Secretary-Treasurer of said Union.

This authorization may be revoked by me as of any anniversary date hereof, by written notice of such revocation signed by me and given to my Employer and the Union by certified mail not less than thirty (30) days nor more than sixty (60) days before any such anniversary date, or on the termination date of the Collective Bargaining Agreement covering my employment, by like notice prior to such termination date, whichever occurs sooner.

"Contributions of gifts to LIFE are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses."

Signature *Francisco Powell* Date *6-19-2015*
 (Please Answer All Questions In Ink)

ALL REPLIES WILL BE KEPT STRICTLY CONFIDENTIAL (OVER)

(PLEASE PRINT OR TYPE) #0506 #0502
 Your Last Name First Name Middle Name Sex Date of Birth
Powell *Quamaine* *Jr.* ☒ M ☐ F *[REDACTED]*
 [REDACTED] *NY* Zip Code *11570*
 [REDACTED] Home Telephone # [REDACTED]
 Name of Employer *Liberty Ashes Inc.* Date Employed
 Full Name of Beneficiary (Example Mary Doe Mr. and Mrs. John Doe) Relationship
 Are you covered by any other health insurance? ☐ Yes ☒ No ☐ Carrier
 If dependent coverage is provided, do you have eligible dependents? Yes ☒ No ☐
 List below all family members to be covered:
 Name Birth Date Relationship
 (Indicate child's name if applicable) MO DAY YR
 SPOUSE'S NAME LAST (If Different) FIRST SS# *[REDACTED]* ☐ Husband ☐ Wife
 DEPENDENT LAST (If Different) FIRST *Powell Jr.* *Quamaine* *6/25/15* ☒ Son ☐ Daughter
 DEPENDENT LAST (If Different) FIRST *[REDACTED]* ☐ Son ☐ Daughter
 DEPENDENT LAST (If Different) FIRST *[REDACTED]* ☐ Son ☐ Daughter
 DEPENDENT LAST (If Different) FIRST *[REDACTED]* ☐ Son ☐ Daughter

I hereby apply for that coverage for which I am or may become eligible under the group policy or policies issued by LIFE Benefit Plan. I authorize such deductions, if any, from my earnings as may be required as my contribution to the cost of such coverage. I designate the above as my beneficiary under any life insurance issued and certify that the above is my correct date of birth. I have read this or it has been explained to me and I am signing on the reverse side.